

Brighton Plastic Surgery

204-206 New Street, Brighton, Victoria 3186

Telephone: (03) 9592 0522/Fax: (03) 95920320

PATIENT LABEL

Surgeon: _____ Day _____ Date _____ Admission Time _____ AM/PM

Procedure: _____

Type of Anaesthetic: Local Anaesthetic IV Sedation General Anaesthetic

PATIENT DETAILS

Patient Surname _____ Other Names _____

Address _____ Post Code _____

For confidentiality and privacy reasons, what telephone number(s) would you like us to contact you on?

(Home): _____ (Work): _____ (Mobile): _____

Occupation _____ Place of Birth _____

Are you a Torres Strait Islander/Aboriginal Yes/No

Date of Birth _____ Age _____ Religion _____

Next of Kin _____ Relationship to you _____ Contact No _____

Person responsible for transport home/carer (Name) _____ Contact No _____

Have you been a patient at Brighton Plastic Surgery before? Yes/No If Yes, when? (year): _____

Medicare No: _____ Reference No: _____ Expiry Date: _____

Veterans Affairs No: _____ Language spoken at home: _____

Ambulance Membership No: _____

ACCOUNT DETAILS

Who is responsible for account? Self Next of kin Workcover TAC Veterans' Affairs Other

If other, is the person aware that they are responsible for paying this account? No Yes

Title: _____ Last name: _____ Given names: _____

Relationship to patient: _____ Contact number: _____

INSURANCE CLAIM DETAILS

All excesses attached to your hospital insurance fund are paid on the day of surgery and are an out of pocket fee (not rebatable)

Privately insured Nil insured Veterans' Affairs Overseas patient

Fund Name: _____ Membership number: _____

Level of Cover: _____ Contributor's Name: _____

WORKCOVER/TAC (please attach accident details)

Workcover TAC Claim no. _____

Date of injury: _____ Name of Insurance Company: _____

Employer's contact details: _____

PATIENT DECLARATION

I agree to be admitted to Brighton Plastic Surgery in full knowledge that all fees and charges have been explained to me and if I have an excess payable on my health fund, this amount will be confirmed with me prior to admission. I release the Hospital from any claims for whatever loss, theft, or damage of my personal property which may occur whilst a patient at Brighton Plastic Surgery.

Patient Signature _____ Date _____

Your procedure time will be confirmed by Brighton Plastic Surgery 48 hours prior

Please turn over and complete the back of this page

Office Use only - Individual Health Identifier (IHC): _____

List details of any previous OPERATIONS

OPERATION	YEAR

PATIENT LABEL

Please answer these questions by **TICKING** the boxes

	NO	YES		NO	YES
Have you had an anaesthetic before?	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from ASTHMA? Do you use a puffer (eg. Ventolin)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any relative ever experienced complications with an ANAESTHETIC?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have had troublesome shortness of breath, persistent cough or sleep apnoea?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any neck or jaw stiffness?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had bronchitis or pneumonia? If yes, when?	<input type="checkbox"/>	<input type="checkbox"/>
Are you ALLERGIC to any drugs, food, tapes, latex or rubber? If yes, give details	<input type="checkbox"/>	<input type="checkbox"/>	Do you or have you had any kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
Did you/do you smoke? When did you cease? ___/___/_____ How many per day?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a diabetic? If yes, Type 1 or Type 2?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? If yes, indicate daily intake.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had Hepatitis, jaundice or liver problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use or have used in the past year any recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have stomach or peptic ulcers, Hiatus hernia, reflux, indigestion or heartburn?	<input type="checkbox"/>	<input type="checkbox"/>
Have you any reason to believe that you are in a high risk group for hepatitis or HIV (AIDS virus)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you or have you had any psychiatric conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a test that showed you had Hepatitis B, Hepatitis C, HIV, MRSA or VRE?	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from Epilepsy, fits, blackouts or faints?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a possibility that you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from eczema or any other skin condition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any special needs? (eg. needle phobia)	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently have any skin wounds, pressure sores or skin ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take ASPIRIN regularly, WARFARIN or 'blood thinning' medication?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any joint replacements?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any treatment for excessive bleeding or bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Have you or any member of your family had or been exposed to infectious/communicable disease in the last 2 weeks? (eg. Flu, shingles, measles)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had Blood clots in the brain, lungs, or legs?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have had Anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	Any further comments?		
Have you ever had a Blood transfusion? If yes, did you have a bad reaction to the transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	List names/doses of all TABLETS/MEDICINES you are currently taking (including unprescribed drugs/herbal/complimentary medicines)		
Have you had a Stroke?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have or have had High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had a heart attack or heart problem (including chest pain, ANGINA, heart palpitations)?	<input type="checkbox"/>	<input type="checkbox"/>	How do you plan to get home when you are discharged?		
Have you had Heart Surgery? If yes, when?			Where will you be staying the night of your surgery?		
<input type="checkbox"/> pacemaker, <input type="checkbox"/> cardiac stents <input type="checkbox"/> heart valve replacement, <input type="checkbox"/> other			Who will be staying with you on the night of your surgery and for how long?		
Height:	Weight:	BMI: (office use only)	Do you require Brighton Plastic Surgery to organise accommodation the night of your surgery? Yes/No		

For patients who will have a general anaesthetic or sedation:

Following surgery I will have a responsible adult drive me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia. I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement for 24 hours.

Signed _____ Date _____

For all patients:

I will follow discharge instructions and attend appointments as advised. The answers I have given to all questions are true to the best of my knowledge.

Signed _____ Date _____